

unequal
TREATMENT.
UNEQUAL
health.

WHAT DATA TELL US ABOUT
HEALTH GAPS IN CALIFORNIA



THE CALIFORNIA ENDOWMENT

ABOUT THIS PUBLICATION

This publication is a joint effort by the National Academy of Science's Institute of Medicine, Cause Communications and The California Endowment. The publication highlights findings from a study requested by Congress entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, published in 2002 by the Institute of Medicine (IOM). This national study was the largest of its kind ever undertaken and was based on published research from more than 100 studies nationwide.

The IOM Committee included leading academicians and researchers from such institutions as Johns Hopkins University, Georgetown University, Harvard School of Public Health, Harvard Medical School, UCLA School of Public Health, UCLA School of Medicine and Emory University.

Also included in this publication are findings from studies by the California Cancer Registry, the Union of Pan Asian Communities, and the California Health Interview Survey, among others. Data from the U.S. Census Bureau, the National Institutes of Health, The Henry J. Kaiser Family Foundation, Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services are also included.

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Consider these statistics:

The infant mortality rate for African Americans is more than twice as high as that of whites.

– California Department of Health Services, 2000

Asian American/Pacific Islanders have the highest rate of liver cancer among all populations, five times that of their white counterparts. Cambodian, Hmong and Laotian men are especially at risk.

– California Cancer Registry, 2000

Hispanic women suffer the highest rate of invasive cervical cancer in California.

– California Cancer Registry, 2000

African Americans living in Los Angeles County have a 78% higher death rate from heart disease than that of the overall population.

– Los Angeles County Department of Health Services, 2000

African Americans, Hispanics and Native Americans have a much higher rate of death and illness from diabetes.

– California Health Interview Survey (CHIS), 2001

*“Disparities in the
healthcare delivered
to racial and ethnic
minorities are real
and are associated
with worse outcomes
in many cases, which
is unacceptable.”*

– Alan Nelson, M.D., Chair, Institute of Medicine Committee
on Understanding and Eliminating Racial and Ethnic
Disparities in Health Care, former president of the American
Medical Association, March 2002

THE PROBLEM

Unequal Treatment and Unequal Health

Inequalities in health reflect some of our nation’s greatest challenges – poverty, lack of access to health insurance, language barriers, cultural isolation and racial prejudice. The result is ethnic and racial minorities do not enjoy the same level of health as whites. These complex societal issues also play into a healthcare system that fails to treat everyone equally.

Ethnically diverse populations do not receive the same kinds of tests, treatments or pain medications as whites suffering from the same diseases. Evidence suggests these disparities in healthcare are associated with higher death rates from such illnesses as heart disease, cancer and HIV infection. On the next page are just a few examples of studies included in the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.

Continued



UNEQUAL TREATMENT. UNEQUAL HEALTH.

In a study of 139 patients at UCLA Medical Center's emergency room, **55% of Hispanic** patients received no pain medication for long bone fractures compared to **26% of white** patients.

Journal of the American Medical Association
Todd, Samaroo and Hoffman, 1993

A national study involving 500 hospitals found **African Americans** treated for colorectal cancer have a 59% to 98% greater chance of dying than **whites**.

Medical Care
Ball and Elixhauser, 1996

A study of 1,392 patients in Southern California, Alabama, Michigan, and Mid-Atlantic States found that **African American** patients were much less likely than **white** patients to have been referred to a transplant center for evaluation, to have been placed on a waiting list, or to have received a transplant within 18 months after starting dialysis.

The New England Journal of Medicine
Ayanian, Cleary, Weissman and Epstein, 1999

In a study of over 19,000 Medicare patients who underwent amputation or leg-sparing surgery, among those with diabetes, **African Americans** were 58% more likely than **whites** to undergo above-the-knee amputation.

The Archives of Surgery
Guadagnoli, Ayanian, Gibbons, McNeil and LoGerfo, 1995



THE PROBLEM

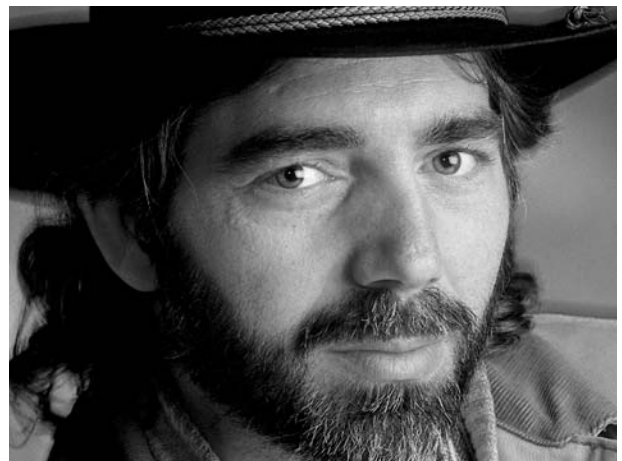
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These inequalities in health status and treatment are found across most racial groups and diseases. It doesn't matter where you live, what age you are, how much money you make or what your insurance covers.

What does this mean for communities of color? Their health status is lower, their death rates higher. In a country founded on the belief that we are all created equal, we have a healthcare system that is not equal or fair for all.

“Racial and ethnic minorities in the United States face higher rates of illness, greater amounts of disability, higher mortality rates and shorter life spans than the white majority. These groups have poorer access to healthcare providers, are more likely to be uninsured or underinsured and are more likely than whites to face cultural and linguistic barriers in attempting to access healthcare.”

– Dr. Harvey Fineberg, President, Institute of Medicine
Remarks from Institute of Medicine/The National Academies
Symposium on *Unequal Treatment – One Year Later*,
March 19, 2003



HEALTH GAPS: PAIN

Lack of pain management within ethnic and racially diverse populations was one of the Institute of Medicine's most compelling findings. A recent study found that 65% of African Americans and Hispanics reported a lack of adequate pain medication. Below are some additional findings from the report that show how people of color are not given the same level of pain medication as their white counterparts.

74%

Percentage of **whites** in an Atlanta emergency department who received pain medication.

Annals of Emergency Medicine
Todd, Deaton, D'Admao, and Goe, 2000

57%

Percentage of **African Americans** in the same Atlanta emergency department who received pain medication.

Annals of Emergency Medicine
Todd, Deaton, D'Admao, and Goe, 2000

63%

The probability – relative to **whites** – that **African American** cancer patients would not receive pain medication upon being discharged from a hospital to a Medicare certified nursing home (from a study of 13,625 cancer patients in five states).

Journal of the American Medical Association
Bernabei, Gambassi and Lapane, 1998



*Most Americans
believe that minorities
receive the same
quality of care as
white Americans.*

– Results of national survey by
The Henry J. Kaiser Family Foundation, 2003



HOW DO WE KNOW DISPARITIES IN HEALTH EXIST?

The Importance of Data

While the perception by most Americans is that everyone receives quality healthcare, the reality is quite different for ethnic and racial minorities. One of the most important factors in being able to achieve balanced healthcare is becoming aware that these inequalities exist. We use data to help us identify and address otherwise hidden health problems. The findings contained in this publication, and the issues they reveal, are only possible because of data collection.

Listening to the accounts of real patients, and becoming sensitive to the obstacles healthcare professionals face, will help solve the problems we now know are real. Why these disparities exist brings to light a host of very complex questions. Data can help move us toward the answers that help reduce disparities.

Knowledge becomes a benchmark for a foundation of positive progress and change. Collecting data is not an issue of race or privacy. It's about gathering facts to give people a voice and help work toward a system that is beneficial and fair to all.

HEALTH GAPS: DIABETES

Approximately 17 million people in the United States have diabetes, and this rate is expected to double in the next 25 years. The disease is poorly managed among ethnically diverse populations, and minorities have a much higher rate of death and illness from diabetes.

In a study of nearly 1,400 Medicare patients, diabetic African Americans were less likely than whites to receive key diagnostic tests.

– *Diabetes Care*
Chin, Zhang, and Merrell, 1998

Rates for African Americans and Latinos over the age of 65 having diabetes are double the rate for whites.

– *California Health Interview Survey*, 2001

6%

Percentage of general population with diabetes.

American Diabetes Association, 2003

10%

Percentage of **Hispanics** with diabetes.

American Diabetes Association, 2003

13%

Percentage of **African Americans** who have diabetes.

American Diabetes Association, 2003

15%

Percentage of **Native Americans and Alaska Natives** receiving care from Indian Health Services (IHS) who have diabetes.

American Diabetes Association, 2003

*“The real challenge lies
not in debating
whether disparities exist,
because the evidence
is overwhelming,
but in developing
and implementing
strategies to reduce
and eliminate them.”*

– Alan Nelson, M.D., Chair, Institute of Medicine Committee
on Understanding and Eliminating Racial and Ethnic
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WHO WE ARE NOW

The Changing Face of California

Taken together, ethnic and racial minorities now comprise more than 50% of California’s population, according to the latest U.S. Census Bureau estimates. And it’s expected that the number of racial and ethnically diverse populations will continue to climb here in California and across the nation. California is a place where more than 100 languages are spoken and where one out of four people is foreign-born. The problem of unequal health and unequal healthcare treatment isn’t a problem for the few; it places the majority of people living here in California at risk.

THE CHANGING FACE OF CALIFORNIA

According to Census Bureau estimates, **whites** comprise 49.9% of the state’s 33.1 million residents, followed by **Latinos** at 31.5%, **Asians** at 11.4%, **African Americans** at 6.7% and **American Indians** at less than 1%.

U.S. Census Bureau, 2000



HEALTH GAPS: CANCER

Cancer is the number one cause of death for Asian/Pacific Islanders in the United States. It's the second leading cause of death for every other racial and ethnic group. And if you're an African American who is diagnosed with cancer, your chances of dying from the disease are greater than any other group. Yet, communities of color are not provided with the screening, test, medication and treatment opportunities that whites receive. As early detection and treatment is a key factor in surviving cancer, this may be one reason for the higher incidence of the disease, as well as higher death rates, for ethnically diverse populations.

Hispanic women are twice as likely as white women to develop cervical cancer. African American, Asian Pacific Islanders and Hispanic women are far more likely to die from cervical cancer than whites.

– California Health Interview Survey, 2001

While the rate of breast cancer among African American women is not as high as that among white women, African Americans are more likely to die from the disease.

– California Cancer Registry, 2000

Hispanic women are far less likely to receive a pap smear than white women.

– California Health Interview Survey, 2001

In a study of over three million women in 10 states across the country, African American women had mammography less often than whites, even across different income levels.

– Journal of the American Medical Association
Burns, McCarthy and Colleagues, 1996

White men are twice as likely to be screened for cancer as Asian men.

– California Health Interview Survey, 2001



UNEQUAL TREATMENT. UNEQUAL HEALTH: FACTS

African Americans have the highest rates of mortality from heart disease, cancer, cerebrovascular disease and HIV/AIDS than any other racial group.

– Annals of the New York Academy of Sciences
Williams, 1999

An investigation of 7,249 hospital discharges in California between 1989 and 1990 revealed that white patients were more likely to receive kidney transplantation and heart procedures (coronary artery bypass graft and angioplasty) than African Americans and Hispanics.

– Archives of Internal Medicine
Giacomini, 1996



Hispanic and African American physicians make up less than 5% of California's physician mix, yet these groups comprise 32% and 7% of the state's population, respectively.

– California Health Index Survey, 2001

Hispanic Americans are almost twice as likely as non-Hispanic whites to die from diabetes.

– Annals of New York Academy of Sciences
Williams, 1999

36% of Asian women have never had a mammogram, compared to 21% whites.

– California Health Interview Survey, 2001

In a study of 13,000 Medicaid patients, 44% of whites received antidepressant treatment within 30 days of the 1st indicator of depression as compared to 27% of African Americans.

– Journal of Clinical Psychiatry
Melfi, Croghan, Hanna and Robinson, 2000



Tuberculosis rates are disproportionately high in Asian American/Pacific Islanders. Tuberculosis affects 34 per 100,000 Asian American/Pacific islanders as opposed to only 2 per 100,000 whites.

– California Department of Health Science, August 2001

In a study of 164 African American and white patients admitted to a hospital, African Americans had a shorter length of stay. In addition, among high socio-economic status patients, African Americans were 3.5 times more likely to receive urine drug screens, regardless of diagnosis.

– Psychiatric Services
Chung, Mahler, and Kakuma, 1995

HEALTH GAPS: MATERNAL AND CHILD HEALTH

Infant mortality rates, one of the most sensitive indicators of the health and well-being of a population, are higher among African American and American Indian/Alaska Natives than any other racial and ethnic groups. This is true even when comparing women of similar socioeconomic conditions.

In 2000, overall infant mortality rate was 5.4 deaths per 1000 live births; for African Americans: 12.8 deaths per 1000 live births.

– California Department of Health Services, 2000

Nationally, Hispanics, African Americans and American Indian/Alaska Natives are two times as likely to receive late or no prenatal care when compared to whites or Asian/Pacific Islanders.

– The Henry J. Kaiser Family Foundation, Key Facts on Race, Ethnicity and Medical Care, 2003

A study of 217,461 singleton first live births among women in California found that African American and U.S.-born Latinas were more likely to undergo Cesarean deliveries.

– American Journal of Public Health
Bravemen, Egerter, Edmonston, and Verdon, 1995



HOW DID THIS HAPPEN?

Racial and Ethnic Disparities in Healthcare

Why do people of color receive a lower level of healthcare? It's true, minorities are more likely to be uninsured, and a lack of adequate health insurance means patients are less likely to receive adequate, timely care. But the Institute of Medicine report found that profound differences exist for people of color even among those who have health insurance.

Evidence suggests that at least two sources contribute to the healthcare gap – the way the healthcare system operates, and the way patients and healthcare providers interact with one another within that system.

The Healthcare System

Data show people of color have access to fewer doctors, fewer hospitals and fewer healthcare centers than their white counterparts. Since fewer resources are available, and transportation is a greater issue, the facilities that do exist are stretched thin. For example, in a study on the availability of opioids (a common pain medication), it was found only 25% of pharmacies in predominantly minority neighborhoods carried sufficient supplies, compared to 72% of pharmacies in predominantly white neighborhoods.

Compounding a lack of health providers, immigrants also have fewer providers who speak their language. Language barriers are a problem for patients and providers in systems that do not have the resources or knowledge to provide interpretation and translation services. This is especially a problem in California where more than 100 languages are spoken statewide. Approximately one out of five Californians – six million people – does not speak English well.

Findings from data indicate poor communication between patient and provider is linked to lower patient satisfaction, lower rates of appropriate follow-up, lower access to specialty care, poorer adherence to treatment plans and a higher likelihood of medical errors. And even for patients who speak English, cultural barriers – such as a lack of familiarity with Western medicine treatment protocols – may also contribute to lower quality of healthcare.

The People in the System: Patients and Providers

Changes in the way healthcare services are paid for and delivered may also pose greater barriers to care for racial and ethnic minorities. In today's health systems, providers often find themselves with high patient caseloads and

Continued

HEALTH GAPS: HIV/AIDS

AIDS is the number one killer of African Americans between the ages of 25 and 44. Yet minorities with HIV infection are less likely to receive antiretroviral therapy and other leading-edge treatments that can forestall the onset of AIDS. Below are data presented in the Institute of Medicine report.

Research shows that lack of quality care is associated with lower survival rates of minorities suffering from HIV/AIDS.

A study of 838 patients from an urban HIV clinic found that 65% of eligible **whites**, compared to only 48% of eligible **African Americans**, received antiretroviral therapy. There were no differences in the stage of HIV disease among these patients.

The New England Journal of Medicine
Moore, Stanton, Gopalan, and Chaisson, 1994

In this same study, 82% of eligible **whites** received PCP prophylaxis, as compared to 58% of **African Americans**.

The New England Journal of Medicine
Moore, Stanton, Gopalan, and Chaisson, 1994





HOW DID THIS HAPPEN?

Continued

pressures to contain costs. Consultations are rushed, often limited to a few minutes. The need to contain costs sometimes limits providers' ability to order diagnostic tests or prescribe more expensive – yet potentially more effective – treatments. Providers not familiar with the culture or language of patients face even greater challenges when trying to treat those patients.

These time pressure and resource constraints are some of the major factors that lead individuals in the healthcare field – even the well intended – to resort to generalizations, or stereotypes, of racial and ethnic minority groups.

While more research must be done to better understand how stereotypes and biases affect the clinical encounter, research has demonstrated that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by a patient's race or ethnicity. In a 1999 study that involved black and white actors playing patients, physicians were significantly less likely to recommend cardiac catheterization for African American females/males than for white females/males.

Another contributing factor in discrimination is the lack of representation of people of color in the healthcare professions. In California, Latinos and African Americans represent 5% of all state physicians, although these groups comprise 32% and 7%, respectively, of the population.

Discrimination against minorities is not something that the vast majority of doctors, nurses, and other health system professionals want to see in healthcare. In fact, racial discrimination is strongly contrary to the professional values and ethics of healthcare providers. But, unfortunately, healthcare does not occur in a vacuum – it is delivered in the context of a society where African Americans, Latinos, American Indians, and other groups receive poorer treatment than non-minorities in many aspects of life. Healthcare's challenge is to rise above these dismaying – and unacceptable – attitudes and behaviors.

Such factors create problems that are as hard to solve as they are to identify. There is an ongoing need to collect information to monitor the progress being made and the challenges that must still be addressed. But regardless, the result is clear: equal health and equal care does not exist for all Californians.

HEALTH GAPS: CARDIOVASCULAR

Heart disease is the leading cause of death for every racial group in the United States, except Asian/Pacific Islanders. Racial and ethnic disparities in healthcare are most evident in cardiovascular care.

African American women are twice as likely as white women to suffer heart disease, yet are less likely to be given certain standard drugs. (Based on a national study of 2,699 women at 20 medical centers nationwide.)

– American Heart Association, 2003

A study of 1,261 patients in New York who received angiography who would have benefited from coronary artery bypass graft surgery, found that African American and Hispanic patients were less likely to undergo the procedure than non-Hispanic white patients.

– Medical Care

Hannan, van Ryn, Burke, Stone, Kumar, Arani, Pierce, Rafi, Sanborn, Slater, De Buono, 1999

In a study of 131,408 patients discharged from L.A. County hospitals, African Americans were less likely than whites to receive bypass graft and angioplasty. Latinos were less likely to receive angiography.

– American Journal of Public Health

Carlise, Leake and Shapiro, 1995

“Effective data collection is the linchpin of any comprehensive strategy to eliminate racial and ethnic disparities in health.”

– Tom Perez, Director and Assistant Professor of Law, University of Maryland School of Law, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, March 2002



WHAT MUST BE DONE?

Before any problem can be solved, it must first be understood. While there may have been general indicators of inequalities in healthcare, collecting and then analyzing data showed conclusively that such disparities were real. The findings of the Institute of Medicine report began to address why these inequalities exist. The report also indicated that much more information is needed to determine the best ways to correct the problems revealed.

Based on the evidence and further analysis conducted by the IOM Committee, the *Unequal Treatment* report made 21 recommendations for action. Six of the 21 recommendations – more than one quarter – pertain to data collection, monitoring and research.

Data can show what changes in current practices must be made, what new programs should be introduced and how to improve the care members of racial and ethnic minority groups receive.

Moreover, it is virtually impossible to know if progress is being made, if the interventions are making a difference, or if health outcomes are improving unless data are collected at the appropriate points in time and in the appropriate way.

Unfortunately, current data collection efforts are inadequate and lack standardization. There are a variety of federal, state and private data sources that collect data using different assumptions and methods. In California, these data include the California Health Interview Survey and the California Cancer Registry, as well as birth and death records. In order to ensure more consistent and regular data collection, the Institute of Medicine recommended that government provide the leadership to spearhead data collection efforts.

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WHAT MUST BE DONE?

Continued

The Institute of Medicine also recognized the challenges and concerns related to the collection of racial and ethnic data. In the past, such data were used to discriminate against minorities, and some distrust persists. In addition, many people – across all racial and ethnic groups – are concerned that their medical information remains confidential and not be used against them in employment or insurance, for example.

Clearly, privacy must be protected and safeguards must be put into place. With such safeguards, data collection and research efforts should be expanded and improved to better understand the various reasons why racial and ethnic disparities occur in healthcare. Both the public sector and the private sector, including health plans, hospitals and other health care institutions, must provide critical leadership in this effort.

The groundbreaking work of the Institute of Medicine report, coupled with other seminal research from numerous respected sources, has helped establish an important baseline of information about the healthcare gaps that exist among ethnic and racial minorities. Clearly, there is a long road ahead before there is equal access to quality healthcare for all. Thus, it is critically important that there are data collection efforts in place so that it is understood how healthcare disparities occur and whether progress is being made to change a system that is neither fair nor equal. Only then will everyone receive the highest quality of healthcare this nation has to offer.

“There’s no way in the world that the country can track its progress in eliminating disparities if we don’t have the data to find out what’s happening...”

– Alan Nelson, M.D., Chair, Institute of Medicine Committee
Remarks from Institute of Medicine/The National Academies
Symposium on *Unequal Treatment – One Year Later*,
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What does this mean for communities of color? Their health status is lower, their death rates higher. In a country founded in the belief that we are all created equal, we have a healthcare system that is not equal or fair for all.

HOW DO WE KNOW DISPARITIES IN HEALTH EXIST?

One of the most important factors in being able to achieve balanced healthcare is becoming aware that inequalities exist.

Listening to the accounts of real patients, and becoming sensitive to the obstacles healthcare professionals face, will help solve the problems we now know are real. Why these disparities exist brings to light a host of very complex questions. Data can help move us toward the answers that help reduce disparities. Collecting data is not an issue of race or privacy. It's about gathering facts that give people a voice and help work toward a system that is beneficial and fair to all.

HOW DID THIS HAPPEN?

Racial and Ethnic Disparities in Healthcare

Data show people of color have access to fewer doctors, fewer hospitals and fewer healthcare centers than the communities of their white counterparts. Language barriers are also a problem in a system that does not always have interpretation and translation services. This is especially a problem in California where more than 100 languages are spoken statewide. Approximately one out of five Californians – six million people – does not speak English well.

Patients and providers find themselves in a system with high patient caseloads and pressures to contain costs. These time pressure and resource constraints are some of the major factors that lead individuals in the healthcare field – even the well-intended – to resort to generalizations or stereotypes of racial and ethnic minority groups.

WHAT CAN BE DONE?

While there may have been general indicators of inequalities in healthcare, collecting and then analyzing data showed conclusively that such disparities were real. Based on the evidence and further analysis conducted by the IOM Committee, the *Unequal Treatment* report made 21 recommendations for action. Six of the 21 recommendations – more than one quarter – pertain to data collection, monitoring and research.

Data can show what changes in current practices must be made, what new programs should be introduced and ways to improve the care members of racial and ethnic minority groups receive. Moreover, it is virtually impossible to know if progress is being made, if the interventions are making a difference, or if health outcomes improve unless data are collected at the appropriate points in time and in the appropriate way.

It is critically important that there are data collection efforts in place so it is understood how health disparities occur. By monitoring progress now, a system that is neither fair nor equal can change. Only then will everyone receive, regardless of who they are or where they came from, the highest quality of healthcare this nation has to offer.

ABOUT THE FINDINGS

This publication is a joint effort by the National Academy of Science's Institute of Medicine, Cause Communications and The California Endowment. It highlights findings from a study requested by Congress titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, published in 2002 by the Institute of Medicine. This national study was the largest of its kind ever undertaken and was based on published research from more than 100 studies nationwide.

Data from the U.S. Census Bureau, National Institutes of Health, The Henry J. Kaiser Family Foundation, the Centers for Disease Control and Prevention, and the U.S. Department Health and Human Services, among others, are also included.



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INSTITUTE OF MEDICINE

The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research, and education. www.national-academies.org

THE CALIFORNIA ENDOWMENT

The mission of The California Endowment is to expand access to affordable, quality healthcare for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. www.calendow.org

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